MISTAKES MADE; LESSONS LEARNED

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One month prior to my appointment as interim Chair on April 3rd of 2015, the ACGME imposed a probationary accreditation status on the department's residency program. At the time of my appointment the department was in the crosshairs of the Dean's office, a poisonous atmosphere existed between the faculty and residents, several of the faculty were under investigation by the hospital GME Office and medical school Faculty Affairs Office for "abusive behavior" towards residents, the clinical service was understaffed by roughly 24% relative to the daily clinical commitments, and the average faculty compensation was bordering on the 4th quartile of the AAMC rankings.

On April 21st of 2016, 12 months later, the ACGME returned the department to full accreditation. In the intervening period the department's entire leadership structure had been reorganized, a 23% increase in the annual budget had been secured, only 2 faculty members left the department, 16 new faculty were hired, the anesthetic service at the health system's cancer center was successfully integrated into the department's responsibilities, and ambitious plans to expand the department's fellowships, chronic pain service, and critical care service were in place.

However, despite these successes I found that my family relationships had become unrecognizable, I was working either clinically or at my computer 18 or more hours a day 7 days each week, and I could barely cajole myself out of bed each morning. The deluge of emails, acute crises, and unfinished projects had nearly overwhelmed my stamina and desire to continue in the position. Although an outstanding leadership team had begun to form within the department, I had allowed the organizational strains to become entirely personal.

The most significant mistake in this instance was the failure to set aside enough time for self-preservation and to establish a regular pattern of disconnecting from the duties of the position. Although retrospective judgments are always somewhat suspect, it is likely that some efforts could have been deferred or delegated with little or no change in the most important endpoints.

Although there has not been a scientific study of the personality traits or behavioral patterns predominant amongst US anesthesiologists I believe that our specialty may be especially prone to this pattern of maladaptive behavior. This may be particularly true for those anesthesiologists already predisposed to accumulating administrative responsibilities over time. Unwavering personal accountability, meticulous attention to detail, and a strong tendency to defer personal needs in order to meet organizational goals are all hallmarks of a successful clinical anesthesiologist. However, in most institutions clinical workflows allow for periods free from professional responsibilities to allow such clinicians to rejuvenate. When applied to administrative tasks and taken to extreme in the context of the 24-7 organizational management structure of an academic medical system these traits can become self-destructive.

The important lesson learned, especially applicable to new Chairs or those entering a period of crisis, is: "Please put your own oxygen mask on first, before helping others."